Modified 5 *As*

Minimal intervention for obesity counseling in primary care

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Abstract

Objective To adapt the 5 *A*s model in order to provide primary care practitioners with a framework for obesity counseling.

Sources of information A systematic literature search of MEDLINE using the search terms *5 A's* (49 articles retrieved, all relevant) and *5 A's* and *primary care* (8 articles retrieved, all redundant) was conducted. The National Institute of Health and the World Health Organization websites were also searched.

Main message The 5 *A*s (ask, assess, advise, agree, and assist), developed for smoking cessation, can be adapted for obesity counseling. Ask permission to discuss weight; be nonjudgmental and explore the patient's readiness for change. Assess body mass index, waist circumference, and obesity stage; explore drivers and complications of excess weight. Advise the patient about the health risks of obesity, the benefits of modest weight loss, the need for a long-term strategy, and treatment options. Agree on realistic weight-loss expectations, targets, behavioural changes, and specific details of the treatment plan. Assist in identifying and addressing barriers; provide resources, assist in finding and consulting with appropriate providers, and arrange regular follow-up.

Conclusion The 5 *A*s comprise a manageable evidence-based behavioural intervention strategy that has the potential to improve the success of weight management within primary care.

Mr Cortez is a 57-year-old man with type 2 diabetes and hypertension. He has been gaining weight since retiring from the military. His body mass index (BMI) is 37.4 kg/m^2, and you are frustrated that he has not followed your recommendations to lose weight. During his most recent visit you told him that if he did not lose weight he faced a future of disability from diabetes. You are concerned about him but wonder if talking about weight is a good use of time. What should your approach be?

Sources of information

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Main message

Primary care is an important setting for obesity management.[1] Yet many primary care providers feel ill-equipped or inadequately supported to address obesity.[2-9] This is in part because obesity outcomes depend more on patient behaviour than on physician recommendations and education. Behaviour change theories exist, as does evidence that behaviour change interventions are effective.[10,11] However, the time and support necessary to learn behavioural counseling are barriers. In this context, minimal intervention strategies such as the 5 *A*s (ask, assess, advise, agree, and assist) can guide the process of counseling a patient about behaviour change.

The 5 *A*s, developed for smoking cessation,[12] can be adapted for obesity counseling.[13,14] The 5 *A*s are appealing, as they are rooted in behaviour change theory (eg, self-management support, readiness assessment, behaviour modification, self-efficacy enhancement) and can be implemented in busy practice settings. However, recent studies show that they are only partially implemented: *ask* and *advise* are used

KEY POINTS Primary care is an important setting for obesity management, yet many primary care providers feel ill-equipped or inadequately supported to address obesity. Minimal intervention strategies such as the 5 *A*s (ask, assess, advise, agree, and assist) can guide the process of counseling a patient about behaviour change. They are rooted in behaviour change theory and can be implemented in busy practice settings.

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but not *agree* and *assist*.[13-15] Nevertheless, when used, *agree* and *assist* were related to diet improvement, and *advise* was related to increased motivation and confidence to change dietary fat intake and to lose weight.[13]

The 5 *A*s are also appealing because they enable providers to raise the issue of obesity, and they can be incorporated into recent obesity classification and assessment models.

Ask. Asking questions (and minimizing statements) is a principle of motivational interviewing, an evidence-based interviewing style that facilitates patient-driven behaviour change.[16-18] Ideal initial questions should seek permission to talk about weight, such as, "Are you concerned about your weight's effect on your health or your quality of life?" and "Would it be alright if we discussed your weight?" This is important because body weight is a sensitive topic for most owing to embarrassment, fear, blame, and stigma, and weight bias exists among physicians, dietitians, nurses, and psychologists.[19-23]

With permission to talk about weight, a nonjudgmental (another core principle of motivational interviewing) conversation is more likely. Nonjudgmental curiosity helps avoid challenges to effective communication. It is important not to make assumptions about the patient's lifestyle—many obese patients might already be working hard at weight management. Language is also important. The term *obesity* might be perceived negatively by some patients.[24] Research suggests that patients prefer the term *weight*.[25] Asking about lifestyle, relationship with food, motivation, etc, reduces any tendency toward biased assumptions, such as unhealthy weight equating with unhealthy lifestyle. Asking can be educational, as in the question, "What do think you could do to better manage your weight?"

An important early step when asking is assessing patient readiness to manage weight. Readiness can be assessed by general questions (such as, "Are you ready to try to work on your weight?" followed by, "Would you be comfortable if I tried to help?"), a readiness ruler (a 10-cm visual analogue scale), or Prochaska's Stages of Change model (ie, precontemplation, contemplation, preparation, action, maintenance).[26] Assessing readiness establishes where the patient is and helps the physician avoid working harder than the patient.

If patients are unwilling or reluctant to talk about weight (asking a question obliges one to listen to the answer), the physician can summarize that this indicates the patient is comfortable with their weight. One can then reassure the patient that if weight becomes a concern the issue can be revisited.

You ask Mr Cortez's permission to discuss his weight. He appears relieved by your nonjudgmental attitude. He shares your concern and frustration and mentions that he downloaded a food diary app, which he stopped using after a few days owing to lack of motivation, and that he has been trying to order "healthier" foods at his office cafeteria.

Assess. Asking elicits important information from the patient. This leads naturally to the second *A*: assess. It is important to assess health status (BMI, waist circumference), the effects of weight on psychosocial factors, and "root causes" of obesity. Health status can be assessed using the Edmonton Obesity Staging System,[27] which ranks patients (stages 0 to 4) based on weight-related medical, psychological, and functional limitations and predicts mortality better than BMI.[28,29] Psychosocial and root-cause factors can be further assessed using the 4 *M*s framework: mental health, mechanical, metabolic, and monetary factors.[30,31]

Mr Cortez has class 2, stage 2 obesity based on his BMI and health status, respectively. In addition, you find symptoms of atypical depression (increased appetite, lack of interest, feelings of worthlessness) that appear to be related to his retirement.

Following assessment the physician can introduce the possibility of change (weight management)—that is, advise.

Advise. Asking and assessing establish a collaborative relationship in which the complexity of obesity is identified for the individual. The next step is to ask permission to give advice—ie, offer a clinical management plan (eg, "Now that we have a better understanding of your situation, can I recommend a plan of action to improve things?"). Patients are likely more receptive when advising follows asking and assessing (another principle of motivational interviewing called *expressing empathy*).

Weight-management advice can be complicated. Current guidelines suggest that all obese patients should be advised to lose weight, but this recommendation is not based on strong evidence. Given the high rates of recidivism, common unhealthy weight-management practices, the negative health and emotional consequences of weight cycling, and the need for ongoing support for weight-loss maintenance, it might be prudent to limit weight-loss advice to individuals experiencing weight-related complications (stages 1 to 4 of the Edmonton Obesity Staging System).[27] Emphasizing personal obesity risks and the benefits of modest sustained weight loss (5% to 10% of initial weight)[32] can be helpful. Those in stage 0 might

benefit from advice to avoid weight gain and reassurance that, regardless of their weight, there are tremendous benefits to healthier lifestyles and that the weight-independent benefits of healthy diets, stress management, adequate sleep, and regular physical activity will mitigate many of excess weight's associated risks. It is also crucial to point out the chronic relapsing nature of obesity that necessitates a long-term weight-management strategy.

Finally, patients should be advised about treatment options, including lifestyle monitoring, behavioural and psychological counseling, medications, low-calorie diets, and bariatric surgery. This is also the time to discuss the benefits and shortcomings of commercial weight-loss programs.

Given Mr Cortez's stage 2 obesity and his depression, you advise him to consider self-monitoring with a food journal, activity log, and regular weighing to help prevent further weight gain. You also suggest he meet with a psychologist for further help with his mood.

Agree. Before proceeding with treatment, it is important to obtain explicit agreement about the treatment plan—that is, the patient's buy-in. Although the physician might believe he or she is in the best position to determine the most effective course of action, it is the patient who must do the work of change. That is why the agree step is so important. Just as many patients might require multiple conversations before they can agree with a physician's recommendations, many physicians might need to modify their recommendations in order to establish treatment plans that particular patients are comfortable following. The agree step is about respectful negotiation.

Research shows that most patients have unrealistic weight-loss expectations and are discouraged when these unrealistic goals cannot be achieved. It has therefore been suggested that patients attempt to achieve a "best" weight that is achievable and sustainable while still enjoying life.[33] Setting goals surrounding weight-management behaviour—and not weight itself—might help patients achieve a meaningful weight loss as, ultimately, it will be behaviour changes that will get them there.

Any treatment plan should use effective behaviour modification principles such as goal setting and behaviour shaping. Goal setting is easily done using the SMART framework (find behavioural goals that are specific, measurable, achievable, rewarding, and timely).[34] Shaping involves sequencing goals that are meaningful and achievable, so that patients experience success and enhanced self-efficacy.

It is important to focus on improving mental and physical health rather than on kilograms lost—success will look different for each patient. Agreement should also be reached about any additional aspects of the treatment plan (eg, adherence to medications, learning more about bariatric surgery, etc).

Mr Cortez appears sceptical about seeing a psychologist, as he does not think he is depressed. After you explain that this is not an uncommon problem and might well be an important cause of his weight gain, he agrees to meet with the psychologist. He also agrees that, for now, simply avoiding further weight gain could be seen as the first sign of "success."

Assist. After agreeing on treatment objectives, physicians should assist patients by identifying and addressing facilitators (eg, motivation, support) and barriers (eg, social, medical, emotional, and economic barriers that can make weight management challenging)[35] to the treatment plan. Consistent with minimal intervention, assisting does not mean that the physician does the work. In fact, given the reality of primary care settings, the role of the assisting physician is to identify, educate, recommend, and support.

Patients should be assisted in identifying and seeking out credible weight-management resources and be referred to appropriate providers for management (ie, emphasizing an interdisciplinary approach). Arranging follow-up is important so that the support of the physician recommendations can continue.

Mr Cortez responded well to the 5 As. By asking permission you were able to identify his communication challenges (your frustration and his fear of judgment). After clarifying your interest he disclosed that he was worried about weight gain. Once you understood that his depression was due to the loss of his work role, which he coped with by eating, he was open to your recommendations. After agreeing that he seek help from a local community-based healthy living resource, he began to take action.

Conclusion

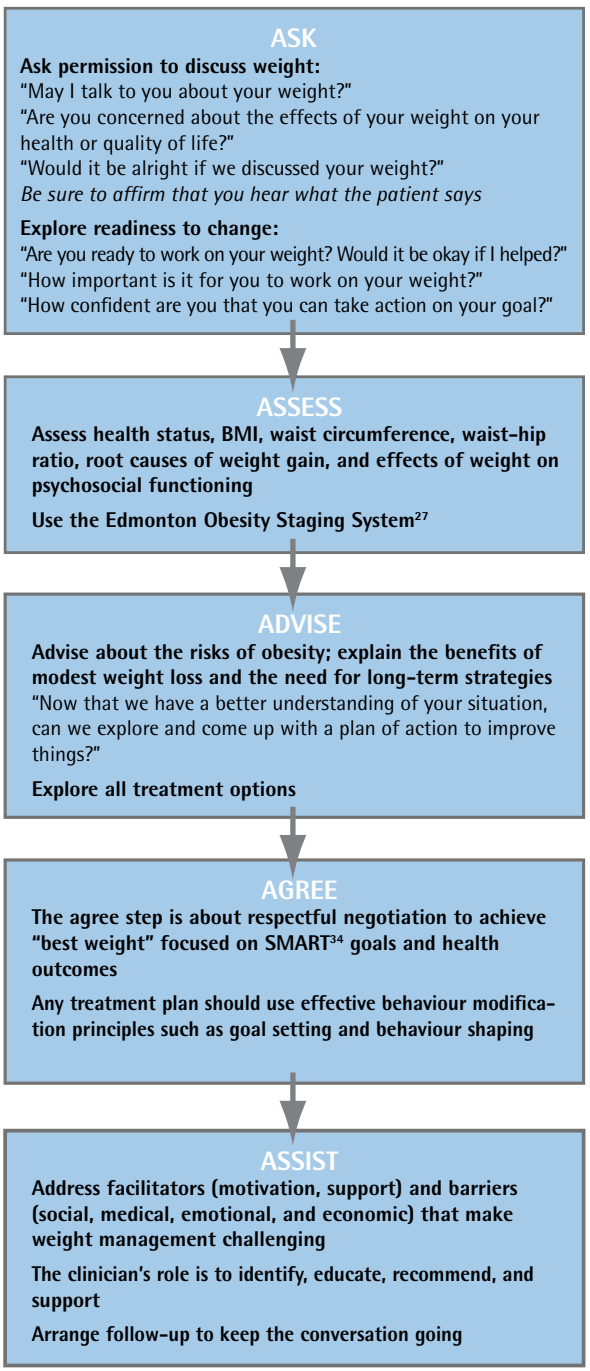
Primary care is a hub for supporting realistic weight-management interventions. Yet the work of behaviour change cannot be taken on solely by the physician. The ideal role for the physician is to start sensitive conversations, achieve agreement on following through with effective weight-management strategies, and support the patient in the initiatives that he or she undertakes. The 5 *A*s, summarized in **Table 1**[34] and **Figure 1**,[27,34] comprise a manageable evidence-based behavioural intervention strategy that has the potential to improve the success of weight management within primary care.

Table 1. The 5 *A*s of obesity management

A	DEFINITION	RATIONALE
Ask	Ask permission to discuss weight; be nonjudgmental; explore readiness for change	Weight is a sensitive issue; avoid verbal cues that imply judgment; indication of readiness might predict outcomes
Assess	Assess BMI, WC, obesity stage; explore drivers and complications of excess weight	BMI alone should never serve as an indicator for obesity interventions; obesity is a complex and heterogeneous disorder with multiple causes—drivers and complications of obesity will vary among individuals
Advise	Advise on health risks of obesity, benefits of modest weight loss, the need for a long-term strategy, and treatment options	Health risks of excess weight can vary; avoidance of weight gain or modest weight loss can have health benefits; considerations of treatment options should account for risks
Agree	Agree on realistic weight-loss expectations and targets, behavioural changes using the SMART framework,[34] and specific details of the treatment options	Most patients and many physicians have unrealistic expectations; interventions should focus on changing behaviour; providers should seek patients' "buy-in" to proposed treatment
Assist	Assist in identifying and addressing barriers; provide resources and assist in identifying and consulting with appropriate providers; arrange regular follow-up	Most patients have substantial barriers to weight management; patients are confused and cannot distinguish credible and noncredible sources of information; follow-up is an essential principle of chronic disease management

BMI—body mass index; SMART—specific, measurable, achievable, rewarding, timely; WC—waist circumference

Figure 1. The 5 *A*s for obesity counseling



BMI—body mass index, SMART—specific, measureable, achievable, rewarding, timely.

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Contributors

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Competing interests

Dr Freedhoff is the cofounder of Bariatric Medical Institute, coauthor, with **Dr Sharma**, of *Best Weight: A Practical Guide to Office-Based Obesity Management,* and author of *Why Diets Fail and How to Make Yours Work.* None of the other authors has any competing interests to declare.

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